

The Southern Regional
Association for the Blind

CONFERENCE REPORT

No 64

Prevention of Blindness:
Achievements
Problems and
Prospects

Report of an address by
Professor Arnold Sorsby CBE, MD, FRCS
given in Westminster, London SW1
on Thursday 13th July 1972

In the Chair
Mr. John A. Wall, MA (Oxon)
Chairman, Southern Regional Association for the Blind

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THE SOUTHERN REGIONAL ASSOCIATION FOR THE BLIND

**Report of a Conference held at Caxton Hall,
Westminster, London, S.W.1
on 13th July, 1972**

Mr. JOHN A. WALL, M.A. (Oxon.), Chairman of the Association,
In the Chair.

THE CHAIRMAN: I would like first to welcome you all to this afternoon's Conference. I feel sure you will find it very interesting and useful, for the task of preventing blindness is a subject of as great interest to blind welfare organisations as the job of helping the blind.

I remember reading a French saying that the duty of a Doctor was to cure sometimes, to help often and to comfort always. Today Professor Sorsby will be speaking to you about the prevention of blindness.

He is, as you all know, a leading authority on eye diseases, and it is a very great privilege and honour to have him with us this afternoon. You will see from the timetable of this afternoon's conference that little more than an hour has been allocated to this first part of it. Professor Sorsby has been kind enough to indicate that he is willing to answer questions; so there will be a little time at the end of the session for this purpose.

I will now ask Professor Sorsby to give us his address, which is entitled, "Prevention of Blindness, Achievements, Problems and Prospects."

PROFESSOR ARNOLD SORSBY, C.B.E., M.D., F.R.C.S.: In trying to assess the present problems it is as well to look back. The first substantial reference to the blind and blindness appeared in the Poor Law Act of Elizabeth I in 1601. This Act was the first recognition by the State of its duty towards the poor of the country.

It was a very permissive Act but it did impose upon such local authorities as existed at that time — mainly vestries — the duty to do something about the poor. In Elizabethan England the poor had had to rely entirely upon the charity of their neighbours and very little upon any organised help. The imposition of definite duties towards the poor upon the local authorities of the day created considerable difficulties.

The local authorities were small and their executives were confined to a limited section of the population; and they tried to pass their responsibility to the next local authority. The result was that the poor became vagrants and migrants. The one exception that was made was for the blind. The blind were given special recognition. Something of the attitude of the deserving and the undeserving poor emerged from that rather undesirable distinction; and the blind were among the deserving poor and were not, therefore, so pushed round from one village to another. That amounted to very little but the first recognition of the rights of blind people, limited though that recognition was, was something of an advance.

The prevailing conditions were grim enough. It took something like 200 years of change before the Poor Law Act had come into existence. The Black Death at the end of the fourteenth century had decimated the peasant population of England. Labour became more expensive. The response of the feudal lords was to enclose land and develop sheep farming. The labourers were being displaced from their lands which were turned over to sheep to produce wool which became a major industry of the country. Thomas More, in his *Utopia*, speaks of sheep eating up the land.

The Enclosure Acts took away more and more of the fertile land from the people who required it for work and subsistence. In addition, the second half of the sixteenth century was a period of severe inflation. The massive inflation that swept through Europe at this time was precipitated by the wholesale plunder by Spain of the silver and gold of what is now known as Latin America.

The devaluation of money and of human beings, created a new class of poor. And over and above all that, the destruction of the monasteries in the reign of Henry VIII had led to the collapse of such social organisation as had existed. As a result of all this England, by the end of the sixteenth century, had an unparalleled problem of poverty; and in that unparalleled problem only the blind received any special recognition.

The next landmark was 1790, when the first institution for blind people was established in Liverpool by Benjamin

Rushton. He had been a sailor on slave ships engaged on unholy trade of transporting across the Atlantic negroes who had been captured in Africa to be sold into slavery on the American continent.

These slave ships, insanitary and mercilessly overcrowded, were floating pest-houses wracked by epidemics which were accepted as one of the risks of the trade. Many of these potential slaves died, and many more were blinded by a virulent infection of the eyes. Rushton himself contracted this infection and had become blind. Not for the first time in history had crime and misery brought some incidental good — but as always at an appalling price.

The nineteenth century saw an unsurpassed development of wealth and of brutality. What happened in that century can best be given in the form of two extracts from a book by Henry Mayhew, a pioneer sociologist, who recorded the way in which people were living in London at the middle of the last century. His *London Labour and London Poor* was published in 1851, and the following two extracts will give you an idea of what blindness meant at that time, and how little was done about it.

“It is upwards of 30 years since I first went to work at the Tailoring trade in London. I learned my business under one of the old hands at Mr. Cook’s in Poland Street and after that went to work at Guthrie’s, in Bond Street. About 15 years ago my eyes began to fail me without any pain at all . . . I could not see anything clear. Working by gaslight at first weakened and at last destroyed the nerve altogether. I am now in total darkness. I can only tell when the gas is lighted by the heat of it.

A great number of tailors go blind but a great many more have lost their sight since gaslight has come up. Candle light was not half so pernicious to the sight. Gaslight is so very heating and there is such a glare with it that it makes the eyes throb and shoot too, if you work long by it. I have often continued working past midnight with no other light than that and then my eyes used to feel like two bits of burning coals in my head.

As you can see, Sir, the worst of it was as I found my sight going bad I was obliged to try it more so as to keep up with my mates in the shop. At last my eyes got so weak that I was compelled to give up work and go into the country; and there I stopped, living on my savings and unable to do any work for fear of losing my sight altogether.

I was away for about three years and then all my money was gone and I was obligated, in spite of my eyes, to go back to work again. But then, with my sight defective as it was, I could get no employment at the honourable trade and so I had to take a seat at a shop in one of the cheap houses in the City; and that was the ruin of me entirely, for working there, of course, I got scratched from the Trade Society and so lost all hope of being provided for in my helplessness.

The workshop at this cheap house was both small and badly ventilated. It was about seven foot square and so low that as you sat on the floor you could touch the ceiling with the tip of your finger. In this place seven of us worked, three on each side and one in the middle. Two of my shop mates were boys or else I am sure it would not have held us all.

There was no chimney, no window that could be opened to let the air in. It was lighted by a skylight and this would neither open nor shut. The only means of letting out the foul air was one of them working ventilators fixed in one of the panes of glass but this didn't work so there we were often from five in the morning until ten at night working in this dreadful place.

There was no fire in the winter, though we never needed one for the workshop was overhot from the suffocation; and in the summer it was like an oven. This is what it was in the daytime; but mortal tongue can't tell what it was at night with the two gaslights burning away and almost stifling us. Many a time some of the men have been carried out by the others fainting for air. They all fell ill, everyone of them; and I lost my eyes and my living entirely by it.

We spoke to the master repeatedly telling him he was killing us, and though when he came up to the workshop his self he was nearly blown back by the stench and heat he would not let us have any other room to work in and yet he had plenty of convenience upstairs. He paid little more than half the regular wages and employed such men as myself, only those who could not get anything better to do. But with all this I don't think my wages averaged above twelve shillings a week. Sometimes I could make it a pound in the week but then the next week maybe I would be ill and would get but a few shillings.

It was impossible to save anything then. Even to pay one's way was a difficulty; and at last I was seized with rheumatics on the brain and obliged to go into St. Thomas's Hospital. I was there eleven months and came out stone blind. I am convinced I lost my eyesight by working in that cheap shop."

That was the story of a man who tried to keep on at his work. The next extract is from the story of a woman limited to being a street musician and to begging:

“I was born on 4th April 1786. It was Good Friday that year. There was a small chandler’s shop facing the *White Horse* in Drury Lane. Father was a hatter and mother an artificial flower-maker and feather-finisher. When I was but a day old the nurse took me out of a warm bed and carried me to the window to show to some people how like I was to father. The cold flew to my eyes and I caught inflammation in them.

Owing to mother being forced to be from home all day at her work I was put out to day nurse when I was two weeks old. My eyes were then very bad by all accounts and some neighbours told the woman I was with that Turners Syrup would do them good. She got some and put it on to my eyes and when poor mother came to suckle me at her dinner hour my eyes were all a gall of blood. From that time I never see afterwards. She did it all for the best, poor woman, it was no fault of hers and I bear no malice for it.

I stayed at home with mother until I was thirteen when I was put to the blind school but I only kept there nine months. They turned me out because I was not clever with my hands and I could not learn to spin nor make sashlines, my hands were a bit awkward like. I had not been used at home to doing anything for myself, not even to dress myself. Mother was always out at her work so she could not learn me and no one else would so that was how I was turned out.

I then went back to my mother and kept with her till her death. I well remember that. When she died I was 16 years old. I was sent to the Union, and father with me for he was ill at the time. He died too and left me seven weeks after mother. When they was both gone I felt I had lost my only friends and that I was all alone in the world, and blind.

But take it all together the Lord has been very good to me and I must thank the good woman I am with. I miss mother the most. She was so kind to me. There was no one like her, not even father. I kept in the Union until I was 20. The parish paid for my learning the cymbal — God bless them for it, I say. A poor woman in the workhouse first asked me to learn music. She said it was always a bit of bread for me. I did as she told me and I thank her to this day for it.

It took me just five months to learn the cymbal, if you please . . . The woman who persuaded me to learn the cymbal took me out of the Union with her. I lived with her and she led me about the streets. When she died I took her daughter

for my guide. She walked with me for more than five and twenty year and she might have been with me to this day but she took to drinking and killed herself with it.

She behaved very bad to me at last and as soon as I got a few halfpence she would go into the pub and spend it all. Many a time I am sure she has been too tipsy to take me home."

The sequel is reported by Mayhew:

'It was during one of those journeys that an accident occurred which deprived London of one of the well known old hurdy gurdy women. In crossing Seymour Street she and her guide, Lisa, were knocked down by a cab as it suddenly turned a corner. They were picked up and placed in the vehicle.

They were carried to the University Hospital. A description of that ride is more terrible and tragic than I can hope to make out to you. The poor blind creature was ignorant of the fate of her guide. She afterwards told us that she kept praying and begging Lisa to speak to her as the vehicle conveyed them to the asylum. She shook her, she said, and entreated her to say if she was hurt; but not a word was spoken, in answer.

Then she thought how terrible a privation was her blindness. It was not until they reached the hospital and they were lifted from the cab that she knew and heard the people whisper to one another that her faithful attendant was dead. In telling us this the good old soul forgot her own sufferings for a time as she lay with both her legs broken beneath the hooped bedclothes in a hospital bed.

When after many long weeks she left the hospital asylum she was unable to continue her playing the hurdy gurdy, her hand being used for the crutch that was needed to bear her on her round. The shock, however, has been too much for the poor old creature's feeble nature to rally against and though she continued to hobble round to the houses of the kind people who for years had allowed her a few pence a week and went limping along through the streets for some months after she left the hospital, her little remaining strength at length failed her and she took to her bed in a room in Bells Court, Gray's Inn Lane, never to rise from it again.'

That was London, 1851. I will spare you the details of the rest of the nineteenth century and come to the Blind Persons Act of 1920. This Act was the first effort towards the Welfare State and those who sneer at the Welfare State today, and seek to erode it, are not only heartless, but also stupid. There is no road back to 1851.

THE BLIND PERSONS ACT OF 1920 AND ITS DEVELOPMENTS

THE BLIND REGISTER.

With the coming of the Blind Persons Act a register was established taking in all who were known to the local blind welfare societies throughout the country — the voluntary societies. The total number of names included on the first register was 25,800.

By 1933 — 10 years later — the original number had increased (in round figures) to 63,000. In 1944 the number was 75,000; in 1953 85,000 and in 1970, a little over 100,000. Of course, there has been no such astronomical increase in the number of blind persons during the past 50 years. The increasing figures are a measure of the unfathomable neglect by the earlier services to deal with the blind. It is also a measure of the change in the definition of blindness.

When the register was established in 1920 the concern was only with numbers. By the end of 1928 attempts were made to establish the causes of blindness; and it became necessary for every new applicant for entry on the blind register, to have a medical certificate of blindness. In the beginning it was nothing more than a certificate stating that the person was blind. But by about 1933 the medical certificate had developed into an authoritative ophthalmological document. A certificate from a general practitioner not experienced in eye disease was no longer acceptable; it became essential for the certificate to be given by an expert in ophthalmology.

CAUSES OF BLINDNESS.

Thus from 1933 onwards authoritative certificates of blindness have been available for study and they have been analysed systematically for some 40 years now by the Department of Health and Social Security. These certificates give an immense amount of detail as regards the causes of blindness. When they are related to the bits and pieces of information that we had of the earlier years, they give us this picture:

(1) *Blindness in childhood.* At the beginning of the century and up to about 1940, the commonest cause of blindness was that setting in at birth; a child born with eyes normal but infected by maternal discharges at birth could become blind within a very few days from ophthalmia neonatorum which, left untreated, was always disastrous (the second extract from Mayhew to which we have just listened is a typical case of ophthalmia neonatorum left untreated).

The first statutory efforts for the control of ophthalmia neonatorum came in 1914, when notification was made compulsory. Shortly afterwards the London County Council established a special hospital to deal with such babies and their mothers. In 1880 an investigation in blind institutes had shown that some 60 per cent. of children admitted to such institutions had been blinded by ophthalmia neonatorum. By 1923 the incidence was down to 30 per cent.

The rest of the story is heartening. By 1943 the incidence had dropped to 10 per cent. of children at blind schools and by 1953 there was only an occasional case of such blindness.

(2) *Blindness in the elderly.* A very high proportion (of the order of 35%) of blindness in elderly people is due to cataract. This is a fantastic situation because if there is one operation in the whole range of surgery which gives brilliant results, very little short of 100 per cent. success it is the cataract operation; and yet the largest single cause of blindness, as shown by the blind certificates from 1933 onwards, was cataract. It continued as the largest single cause until about 1955. Then it dropped substantially. It appears that until 1948 aged persons, blind from cataract, often failed to seek advice.

In 1948 the National Health Service Act provided a general medical service for everybody, no longer for just panel patients, as in the past. Then, for the first time, needy old people, blind from cataract, who had been sitting at home, becoming more and more decrepit mentally and physically, had ready access to general medical advice and referral to hospitals.

That was the start of gratifying developments. The blind certificates had shown that some 80 per cent. of those blind from cataract had never seen an ophthalmologist till registered as blind. In 1953 the Ministry issued a circular asking general medical practitioners to collaborate with hospitals by sending these elderly blind people to eye hospitals for investigation. To cut a long story short, between 1948 and 1960 the incidence of blindness from cataract fell by 25 per cent. I do not have the figures on what has happened between 1960 and 1972 but it is certain that this decline has continued since then; and it is likely that blindness from cataract will cease to be a major problem in this generation.

(3) *Blindness in premature infants.* Until recent years markedly premature infants weighing at birth $2\frac{1}{2}$ to 3 lb. died soon after birth. Then in the early 1930s and 1940s new methods of care for such premature children enabled them to be kept alive. But by the middle of the 1940s it was realised that many of

those survivors were blind. Ultimately, their blindness — retrolental fibroplasia — was traced to the methods of treatment that were used to keep the prematures alive.

The main method of treatment that was responsible for this was the then accepted use of oxygen. Between 1945 and 1960 in England alone, something like 600 to 800 new-born children were blinded by retrolental fibroplasia; when the use of oxygen for such treatment was restricted and new methods of treatment for these markedly premature infants were instituted, the incidence of the affection declined substantially. It has not been entirely eliminated — there are still something like 10 babies each year blinded from this disorder.

(4) *Blindness from diabetes.* Diabetes produces blindness from damage to the retina — diabetic retinopathy. This was uncommon in the early years of the century, because people who suffered from diabetes sufficiently severely to become blind died. Since the twenties treatment of diabetes by insulin has led to the survival of diabetics, able to live a normal life — normal, that is, except for the complication of eye disease in diabetics.

Practically all the complications of diabetes are controlled and prevented by the use of insulin; but there is obviously an additional factor in the development of diabetic retinopathy, which is not influenced by insulin. We have not isolated this factor and the result has been that over the past two generations the incidence of blindness from diabetes has increased very markedly, almost year by year, as more and more diabetics have survived. It has now become stationary because saturation point has been reached: the diabetics who were liable to develop this condition have done so by now; and no more diabetics who previously would have died are alive to add to the quota.

Diabetic retinopathy is a serious problem. It accounts for some 20% of the total of new registrations between the ages of 40 to 64 years.

(5) *Blindness from glaucoma.* There are several types of glaucoma. That seen in infancy is severe; it is sometimes called buphthalmos because the eye enlarges, and becomes like the eye of an ox; the outcome is unfavourable. There is also the glaucoma of young people which is only a slightly less severe affection. As for the glaucoma of the middle-aged and elderly, this runs a very mild course but is, unfortunately, very common. Amongst the people with this very common disease there is a small proportion in whom it runs a severe course leading to blindness.

Overall, glaucoma is responsible for a considerable proportion of blindness today — some 12% of new registrations.

(6) *Other Causes of Blindness.* (i) “senile macular degeneration”. This is not really a blinding disease in the classical sense; a macular lesion destroys useful central vision, making it impossible to read type, but it does not destroy peripheral vision, that is, the rest of the retina is intact and such patients can get about. It is a substantial and increasing cause (of the order of 25% of new registrations) because of the increasing number of elderly people. In spite of its name it is not an aspect of senescence; only a small proportion of elderly people are affected.

(ii) Inflammation of the interior of the eye: iritis and choroditis. This is responsible for some 3 per cent of new registrations; the cause is generally unknown.

(iii) Abiotrophic disorders. These are hereditary diseases that become manifest in adult life, retinitis pigmentosa is the classical example. They account for some 12% of cases in all groups aged from 15 to 50 years.

PROSPECTS.

I have told you of what has been achieved in ophthalmia neonatorum, cataract and retrolental fibroplasia. Is anything comparable being done for diabetic retinopathy, glaucoma, “senile macular degeneration”, or the inflammatory disorders? In practical terms, the answer is no.

The problem of glaucoma is exceedingly complicated; it is a mixture of problems. We have first to identify those patients who have glaucoma. Secondly, we have to identify patients with glaucoma which is running a severe course. In both instances little has been achieved.

As regards senile macular degeneration we do not know why a relatively small proportion of the total of elderly people develop this condition. With iritis and choroditis we are up against the same difficulty that we face with rheumatoid arthritis: a common disorder of unknown origin.

What does all this amount to? First as regards blindness in childhood — between 1923 and 1943 the incidence of blindness in childhood declined to 50 per cent. of the 1923 figure; it has remained stationary because now we have come down to bedrock — the hereditary disorders of the eye for which at the present we have no answer although we have defined the problem. (Incidentally when I speak of heredity I do not mean syphilis. An older generation equated all hereditary disease with inherited syphilis. That was a serious misunderstanding.

But 50 years ago when there was very little understanding of the nature of hereditary disease these things were confused).

Now we have a clearer understanding of heredity, not only of hereditary features of the normal but also of hereditary diseases. We inherit from our ancestors not only their physical traits but also latent possibilities for disturbances. When these latent possibilities are present in both parents they produce children, 25% of whom suffer from diseases which were only latent in their parents; these are known as recessive diseases. There is also an occasional transmission from generation to generation (dominant diseases) but this is relatively rare. There is also occasional transmission — as with haemophilia — through women who are themselves unaffected (sex-linked recessive diseases).

The bulk of blindness in childhood will be overcome only when we have a better understanding than we have now of the nature of hereditary disease and how to control it. Ten years ago few would have ventured to suggest that the control of hereditary disease was an immediate possibility. But we have learnt much during the past 10 years and promising advances are now possible. It is not beyond the realm of probabilities that in the coming generation these diseases will be brought under control — repeating the achievement of our immediate predecessors who got infectious diseases under control.

With regard to blindness in the young and the middle-aged, most of this arises from diabetes, the inflammatory diseases and the abiotrophic disorders. For the present we have come to a full stop in these conditions, as we have with the problems of glaucoma and macular degeneration in the ageing.

We have almost fully exploited the basic work done by our predecessors. We have applied what was possible to the existing problems. We now face a series of problems some handed on to us by the previous generation and some of our own making. In my opening remarks I stressed how much the previous generations had thrown into our laps by their neglect of the basic requirements. What we pass on to the future is a measure of our neglect; and we should do better than our predecessors.

The problems of today may die tomorrow, or they may proliferate. It is also possible that they may change. It may be that in our existing society we are preparing new disturbances which we do not even visualise today. It is a mistake to think of ophthalmic problems as purely medical problems; they are part and parcel of the changing social scene. The medical problems of tomorrow will also be part and parcel of the social problems of the age.

In our quest for endless material goods we have created pollution, and in our quest for health we have created considerable problems of population. The pressure of population, the exhaustion of resources that are being forecast for the immediate future, the pressure of pollution, the pressure of all kinds of vested interests pushing all kinds of undesirable developments, all these are creating problems that are more easily avoided than remedied.

In concrete terms it amounts to this: we have unsolved problems that we have inherited, and we are creating problems that will mature in the future — we have to deal with both. In the first place, we must recruit and mobilise all possible resources to deal with the well-defined medical issues of the day. Secondly, we must resist with all the strength at our disposal all anti-social acts and all attempts to erode the services that have developed. Thirdly, we must think of tomorrow as well as of today.

Shakespeare through Macbeth speaks of life as “a tale told by an idiot, full of sound and fury signifying nothing”. If you believe that then you need do nothing. But there is an alternative view of life given by Shelley in *Prometheus Unbound*:

“To suffer woes which Hope thinks infinite;
To forgive wrongs darker than death or night;
To defy Power, which seems omnipotent;
To love, and bear; to hope till Hope creates
From its own wreck the thing it contemplates;
Neither to change, nor falter, nor repent;
This, . . . is to be
Good, great and joyous, beautiful and free;
This is alone Life, Joy, Empire and Victory.”

THE CHAIRMAN: As I indicated when introducing Professor Sorsby, he has said that he is willing to answer any questions that any one of you may like to ask.

QUESTIONS AND DISCUSSION

MR. P. SHARPE (West Sussex Association for the Blind): I am interested to hear Professor Sorsby talk once again of the incidence of cure of cataract by operation. But one notices, in dealing with these registers, there are a very large number of combined conditions, where there are other complications with the cataract. The lay mind wonders whether perhaps the complications arise because the cataract has not been treated sufficiently early. Certainly, there are many people with cataract associated with other conditions nowadays.

THE CHAIRMAN: As I understand it the question is: Does the delay which is inevitable in treating cataract by operation tend to cause other eye troubles? Does anyone else wish to ask a question?

MR. M. P. CAMPBELL (London Borough of Tower Hamlets): Would Professor Sorsby like to say something about the special hospital opened by the L.C.C. for the care and treatment of ophthalmia patients?

MR. W. E. DOUGLAS (West Sussex Association for the Blind): Most of the people on the register are not — in the sense that I understand total blindness — blind. They have a certain amount of sight. I should say no two individuals have exactly the same amount. How much research is going into improving liability to lose what small amount of sight those people have?

COUNCILLOR A. W. HABBERLEY (London Borough of Hackney): Is there any proof or evidence whatsoever that excessive watching of television appears to have any effect on the eyes?

THE CHAIRMAN: I do not know what the answer to that particular question from Professor Sorsby will be, but I am certain that whatever effect watching television has on the eyes, it certainly has a very deteriorating effect on the brain!

MRS. I. H. OLIVER (Rutland County Council): Is there any information as to the increasing amount of blindness due to glaucoma and if so, to what may this be due?

PROFESSOR SORSBY: The name of the hospital organised by the L.C.C. for the care and treatment of babies with ophthalmia neonatorum was St. Margaret's, in Sheffield Street, W.C. When war broke out it was transferred to White Oak Hospital, Swanley, an L.C.C. hospital for children suffering from chronic eye disease. During the war years and later, from 1940 to 1952, something like 1,200 babies with ophthalmia neonatorum were treated without a single baby becoming blind. They were saved from blindness because in 1936 the sulphonamide, M. & B. 693, and in 1944 penicillin became available. Treatment of ophthalmia neonatorum which previously had to be maintained for many weeks, was reduced through sulphonamide to a matter of days and to a matter of hours with penicillin. The result was that babies who were admitted went out completely cured within three or four days.

To answer another question, there is no evidence that there is any increase in the incidence of blindness from glaucoma. Going only by statistics it would seem that the incidence of

blindness from glaucoma — and indeed of other causes had increased fourfold between 1920 and 1970. But of course these figures have to be interpreted in the light of the facilities available for registration and the willingness of people to seek such registration. It would be a very sad thing if during 50 years of intensive medical activity the incidence of blindness from glaucoma had increased. What has increased is recognition of glaucoma as a cause of blindness. Although I cannot give actual figures I would say that in all probability the incidence of blindness caused by glaucoma has declined.

With regard to the effect of watching television, I would like to lend what little authority I have to damning television; but I am afraid I cannot do it on purely ocular grounds.

There was a question on the degree of blindness; there are many people on the blind register with some degree of vision. That is partly responsible for the fact that the numbers have risen from 25,000 to 100,000. I have been told by one of my older colleagues that at the beginning of the century he visited a blind school at which one of the children bent down and picked up a ball of silver paper which had fallen down. The powers-that-be sent that boy out of the blind school as they held that if he could see to pick up the ball he could not be blind. That meant that such blind services as were then available — and they were charitable, not welfare services — were very rigidly limited and given only to the totally blind.

Among 100,000 registered blind only a small proportion, about 5 per cent. of those on the register, are totally blind in the sense that they have no perception of light. Another 10 per cent. have perception of light; and another 60 per cent. have enough vision to be able to distinguish objects which are near to them — less than 3/60. The statutory definition of blindness is not total blindness but visual disability of such severity, as to make the patient unable to engage in any work for which sight is essential.

This definition was framed before 1920, and it is not generally applicable now because 70 per cent. of those who are registered as blind today are over the age of 70, so the question of doing work for which eye-sight is essential is not as relevant as it would be during the active years of life. It is, however, clear that there is a considerable proportion of people registered as blind who have a fair amount of sight. Some of them have progressive affections which will extinguish what sight they now have: some suffer from macular degeneration which is a stationary disorder: yet others are suffering from early stages of cataract which ultimately will extinguish sight but which can be remedied by operation. Aids for low vision have some

limited (and rather over-rated) use; what is important is that the ophthalmic services should be sufficiently well organised to deal with every individual, whether registered or not, who has ophthalmic problems as distinct from total blindness.

There was a question on complications in cataract operations. Of course, there are such complications but the cataract operation, as I have said, gives some of the most brilliant results in the whole range of surgery. Those who come for registration as blind after a cataract operation are a very small proportion of the total number of cataract patients. Something like 25,000 cataract operations are undertaken each year. The number in which complications develop are few.

I was asked whether there are any complications which arise from non-treatment of cataract. The answer is yes. If cataract is neglected it can go beyond the stage of treatment; apart from the fact that the patient will have become older and less able to stand an operation, the cataract itself tends to swell and produce a secondary glaucoma which can be very painful and not easily remedied. Not only should cataract operations be undertaken to restore sight, they should also be undertaken to prevent unnecessary complications.

VOTES OF THANKS.

THE CHAIRMAN: I am sure we are all very grateful to Professor Sorsby for his talk. I will now ask Miss C. B. Smith from Derbyshire if she will be good enough to propose a formal vote of thanks to him.

MISS C. B. SMITH (Derbyshire County Council): Professor Sorsby, we thank you very much for this most interesting survey of blindness throughout the years and the comforting developments that have taken place in your period of specialisation in this field. You have reminisced and it is perhaps only fair that I should be permitted to reminisce also, and to give a short historical survey of your service to the Southern Regional Association for the Blind, and in particular your service to Home Teachers.

I can recall in 1943 the first time you came among us. That was at Brentwood when there was a refresher course — the first one ever held by the Southern Regional Association for the Blind. Those of us who attended afterwards talked so much about it that our colleagues must have been tired of listening to us, we were so enthusiastic. It was a wonderful experience which we thoroughly enjoyed. That was the beginning of many more appearances and very much help that we received from you.

Those who have been unfortunate enough to be in hospital and have had a professor standing at the foot of your bed with several doctors, all conversing and discussing your body will know that they never seem to think that their discussion has anything to do with you. They concern themselves only with what is happening.

We have to admit that Professor Sorsby is the most kind professor one could ever meet. His contact with the patient as well as the staff has been really wonderful. I am glad Professor Sorsby has been with us today to renew his acquaintance with us and to give those colleagues and friends who have not heard him before an opportunity of doing so. I thank him most sincerely on behalf of us all.

The vote of thanks was carried with acclamation.

ALDERMAN M. A. GOODMAN (Coventry City Council): Mr. Chairman, I am sure all those who are present would not wish this meeting to close without our expressing our grateful thanks to you for presiding over the Conference this afternoon. With this I would couple the thanks of those who were present at our General Council Meeting this morning for presiding over that meeting so ably. This afternoon, as usual, you have conducted this Conference with efficiency, something which is now so much a part of you that we have come to expect it of you. But many Chairmen can be efficient. Where the Chairman of our Association scores is that he can handle a meeting of this kind not only efficiently but with such charm and good humour.

On behalf of all of us here this afternoon, Sir, we thank you for taking the Chair (*Applause*).

THE CHAIRMAN: I thank you all very much.

The Conference then closed.

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